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ABSTRACT

Papers included in the documents are: (1) "Nursing Education for the Community" by Shirley Chater, (2) "Key Problems in Implementing Associate Degree Nursing Programs" by Elsa L. Brown, (3) "The Allied Health Professions Projects at the University of California" by Mary E. Jensen, (4) "The Profession's Involvement in Legislation" by Helen V. Connors, (5) "Who Should Pay for Nursing Education?" by Mildred Montag, (6) "New Curriculum Developments" by Patricia A. Hyland, (7) "A Health Continuum Approach to the Teaching of Technical Nursing in the Associate Degree Program" by Martha Valliant, and (8) "Who Shall Teach?" by Marion I. Murphy. (JK)

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CONTENTS

NURSING EDUCATION FOR THE COMMUNITY 1

Shirley Chater

KEY PROBLEMS IN IMPLEMENTING ASSOCIATE DEGREE NURSING PROGRAMS 5

Elsa L. Brown

THE ALLIED HEALTH PROFESSIONS PROJECTS AT THE UNIVERSITY OF CALIFORNIA 9

Mary E. Jensen

THE PROFESSION'S INVOLVEMENT IN LEGISLATION 14

Helen V. Connors

WHO SHOULD PAY FOR NURSING EDUCATION? 20

Mildred Montag

NEW CURRICULUM DEVELOPMENTS 25

Patricia A. Hyland

A HEALTH CONTINUUM APPROACH TO THE TEACHING OF TECHNICAL NURSING IN THE ASSOCIATE DEGREE PROGRAM 40

Martha Valliant

WHO SHALL TEACH? 43

Marion I. Murphy

NURSING EDUCATION FOR THE COMMUNITY

Shirley Chater

One day in 1930, 34 educators, most of them junior college administrators, attended a conference that was later to be known as the first meeting of the American Association of Junior Colleges. Since then, the junior college movement has continued to develop and flourish under the direction of the AAJC. Junior, or community, college programs have been successful in large part because they have met well-defined educational demands.

As the AAJC tackled problems of general versus technical educational programs and the role of the college in the community, the National League for Nursing Education was wrestling with the implementation of two position papers: Nursing for the Future (1948) and Nursing Schools at Mid-Century (1950).

In 1951, a terminal program for nursing education within the junior college was born when the five-year Cooperative Research Project was launched at Teachers College under the direction of Mildred Montag. Teachers College included members of the AAJC on the advisory committee to the project. Thus, for a long period of time, members of the AAJC and members of the nursing profession have worked both independently and interdependently to develop nursing education for the community.

It is important to note that these early studies were designed with several purposes in mind: (1) to develop a new type of program for nursing, (2) to evaluate the graduates of the new program, and (3) to determine whether a nursing program could become part of a junior college. The associate degree nursing program is distinguished for its systematic plan for development, implementation, and evaluation.

The success of these terminal nursing programs has been due to a variety of reasons. Unlike many other endeavors in nursing education, the rationale basic to the planning of the programs was educationally sound and especially relevant to modern times. The planning year prior to program development was intimately related to the subsequent success of a program. Recruitment of faculty who were knowledgeable about the junior college environment and skillful in curriculum development for technical nursing practice was an important factor. Interpretation and explanation of the program to the community at large were expenditures of time that reaped rewards.

The program as described by Montag in 1951 is still essentially unchanged. The two-year program was a new program. It was not a three-year hospital program condensed, congealed, or otherwise made small enough to be contained within a two-year period. And the two-year period was generally presumed to be two academic years in length.

Montag described nursing practice as a continuum along which different kinds of functions would be identified. The associate degree program would prepare nurses for technical nursing practice; the practitioners would be called "nursing technicians."

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Part of this paper was derived from a study supported by USPHS Training Grant NPG-277-02 to the University of California School of Nursing.

Curriculum, to fulfill the goal of technical nursing practice, was to be organized around a generalized concept of nursing rather than medical diagnosis or geographical location of patients.

Although the specifics of the ADN program were not spelled out, the recent American Nurses' Association's Position Paper does, indeed, again call for differentiation of nursing and clearly states that minimum preparation for the technical nurse should be associate degree education in nursing.

Utilizing these basic assumptions, then, what is nursing education for the community? How do we perceive the associate degree program in 1969?

The ADN program and the purpose for which it exists cannot be viewed in isolation from general nursing practice. The field of nursing can be described as a technology, since the properties of a technology include action, attention to individual needs, and an immediacy about the action taken to serve these needs. Technology is based on accepted principles of practice, i.e., actions that are so systematically organized that others might use them to achieve the same ends. Technologists who utilize principles of practice with material objects are engineers. Those whose clients are human beings are practitioners--hence, nursing practitioners.

Viewing nursing as a continuum of practice, it appears that nursing technicians or nursing practitioners in ADN programs take up most of the space on the continuum. In 1968, the greatest number of practitioners were technical. At the other end of the continuum, we can visualize the professional practitioner of nursing, described by the ANA Position Paper as one who must have the minimum of a baccalaureate degree in nursing. Masters and doctoral practitioners may well be added in comparatively small numbers to the continuum.

It is not within the scope of this paper to describe all kinds of nursing practice, but surely, we--and I am including each junior college administrator and faculty member and nurse educator--must be thoroughly conversant with the aims of technical nursing practice and the curriculum designed to fulfill those aims.

Technical nursing is characterized by those accepted rules of action or principles of nursing practice that are common, recurring, controlled, and immediate. To state it from the problem point of view, the technician deals with individual patient problems that commonly occur and for which there are accepted, well-controlled (standardized) nursing actions. These nursing actions are likely to be standardized and validated through observation.

Technology's aim is to control environment. As control is established and practice acts become fairly well standardized, these nursing practice acts are delegated to others--sometimes within the field of nursing, sometimes to new personnel who subsequently develop an allied specialty of their own. The preparation of a hypodermic injection and the selection of medications were once fairly complex procedures involving cognitive and manual skills. As these procedures were simplified through technical advances, they were in many instances delegated to personnel with less preparation.

A word about the professional practitioner, the baccalaureate graduate. She, too, utilizes principles of practice, and it is easier to say they should be complex, uncontrolled, and uncommon than it is to prove. She utilizes many of the same principles as the technical nurse, obviously not with the same degree of proficiency. It is obvious also that she has a different theoretical base from which to choose and evaluate appropriate nursing actions. She has had a different curriculum, enabling her to explore, modify, and change the rules of action, depending upon the patient variables and the

theoretical bases relative to the problem in question. As such, the baccalaureate graduate may not only prescribe and give patient care, she may also change patient care; her prescriptions may include changes in standardized nursing practices for both professional and technical practitioners.

Curriculum development for the faculty of an ADN program presents a challenge. An understanding of nursing practice in general is essential. A specific conceptualization of technical nursing practice is vital in order to know what to teach and what not to teach.

One must select content to fulfill objectives calling for knowledge and select learning experiences to fulfill those objectives concerned with thinking, values, attitudes, and skills. Utilizing the definition of technical nursing previously described, it would seem that curricula could be organized around common individual patient problems, i.e., what to do for patients and how to do it. Ruth Matheney's book Fundamentals of Patient-Centered Nursing supports this idea.

If the principles of technical practice or the rules of action are carefully selected for the common recurring problems, the focus is undoubtedly upon nursing. It leaves little justification for curriculum design, which utilizes areas of specialization, whether they be geographical or anatomical. In fact, one questions the need for all students to have all experiences. Creative use of learning experiences and creative use of faculty may well reduce the costly, high student-faculty ratio.

If the focus is on nursing practice and the needs of individual patients, it matters little where the patient is located. The objective of ADN programs of 20 years ago--"patient care at the bedside"--may have sufficed for the 1950's; but in the 1970's, the bedsides will have moved. Will our technical nurses have moved with them?

The definition of nursing practice set forth today provides little occasion for the last-minute addition of favorite subjects, medical diagnoses, tasks-which-graduates-may-do-later, leadership, and research. Better organization of content, i.e., principles of nursing practice based on common problems of patients, should make the program shorter. On this basis, summer sessions could be questioned. They are expensive in time and money and often serve the purpose of an internship, which is clearly not a goal for nursing education for the community.

In summary, the proposed theoretical framework for technical nursing is based on Montag's early exposition, the systematic studies of ADN programs during the 1950's, the modifications made by other nurse educators, and the differentiation projects now under way at numerous schools throughout the country. An understanding of technical nursing practice as it relates to and is differentiated from professional nursing practice should provide at least one basis for making curriculum decisions for nursing education for the community.

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KEY PROBLEMS IN IMPLEMENTING ASSOCIATE DEGREE NURSING PROGRAMS

Elsa L. Brown

It is a most pleasurable experience to share in this panel discussion. At the initial point of this paper, I would like to "take my hat off" to the college administrators and to my peers, the nurse directors or department chairmen in this audience, for you have, are, and undoubtedly will continue to accept the tasks of resolving the key problems in the implemention of associate degree nursing programs.

Today, no one argues that the two-year college plays a most dominant role in our nation's system of higher education nor that associate degree programs in nursing, within a two-decade span of development, have had the most rapid growth pattern of any curriculum pattern in our country's history of higher education. Therefore, it would be obvious to assume that the classical writings of both the two-year college development and those in associate nursing education would document problems of the past. Years ago, Cicero wrote, "Not to know what has transacted in former times is to continue always as a child. If no use is made of labors of the past, the world must always remain in the infancy of knowledge."[1]

Are the problems already documented in associate degree nursing still with us? Are they partially resolved, extinct, or have new problems been added to this rapidly expanding field? I thought I'd come to Atlanta today and "tell it like it is."

Therefore, in January of this year, just eight weeks ago, I sent an opinionnaire to five selected department chairmen of ADN programs in each of the jurisdictions of the six regional accrediting agencies. The only criterion used for the selection of the nurse chairmen was that the program they administered be of recent origin, meaning from one to three years old.

The word "opinionnaire" was used because the selected nurse chairmen were requested to state opinions of problems and also make constructive suggestions from their experiences that I might share with you today. Opinionnaire returns were identified by accrediting region only. Eighty percent of the opinionnaires were returned within a four-week period. And they were loaded with points to stress, often underscored three or four times or capitalized. Unfortunately, time does not permit for all opinions to be shared with you, but while some documented problems in associate degree nursing appear to be still evident, one or two new problems have been added.

Nurse chairmen stated the following regarding "on-campus problems" in initiating/implementing programs:

1. The need for an essential planning period. A six-month period of employment of the nurse chairman prior to enrolling the first class of students was too short a period of time. One academic year in advance allows for solid planning, recruitment of faculty, campus and community study and dialogue, et cetera.

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2. First-year faculty members have the opportunity to plan together prior to the admission of students. The polled opinions varied from one to six months of planning time, with an average of three months as being the most feasible amount of time. But, as stated by the Western region, "How can one get college administration to see this one, since no other teacher is hired until the semester opens?" The selected nurse chairmen wish to stress the fact that there are differences in the kinds of laboratory experiences needed for this program, often involving a number of community agencies. To be most productive, faculty must become familiar with their laboratories, and as these are predominantly health care facilities, much of the planning period involves attitudinal relationships which are not comparable to standard lab book exercises. As Anderson writes in her report of the four Kellogg Project states, "A factor considered to be the chief contributor to the success of individual new programs was the provision for a planning period preceding admission of the first class."[2]

3. Lack of in-depth understanding of the objectives of the ADN program by non-nurse faculty. The following are regional opinions and suggestions:

   New England--Plain resistance of the general college faculty toward so-called technical programs. The in-depth understanding of the college president was probably the most helpful factor in relation to potential problems with non-nurse faculty.

   Middle States--A problem, true. Talking does not seem to make much of an impression. Several short sessions in faculty senate devoted to ADN development and current campus plans were a tremendous help.

   North Central--Continue to stress this one--it takes so much time, and nurses need some understanding, too.

   Southern--Set up a committee for orientation of faculty, college staff, and the community. Have this committee include general educators. Meet with department chairmen and especially student personnel officers quarterly for ongoing interpretation.

   Does this area of lack of understanding show that we all have a tendency to exist in a watertight compartment? Do we have situations of "duologue" rather than dialogue? This on-campus problem was quite meaningful to this speaker, as statistically, today, 25 percent of our ADN programs are within university structures.

4. Funding of programs. The seeking of funds as seen by the majority of nurse chairmen is a task that must be assigned to an administrative officer of the institution. The chairmen generally felt that they lacked sufficient updated knowledge and the time to seek funds, but they also questioned whether this should be one of their major responsibilities.

Not all of the key problems are on campus. Major community, or "off-campus," problems, as polled, were:

1. Continued interpretation of the value of the program. This interpretation should not be directed to the general public as one might suspect, but rather to guidance counselors and "nursing care" personnel. Suggestions for opportunities to develop an ongoing dialogue with these groups ranged from community and regional health career councils to open houses on campus; to quote a Western region comment, "Allow the new chairman the time and the freedom to contact groups on a continuing basis." Most essential within group contacts are the many different kinds of workers who compose the staffs of health agencies. Interpretation goes beyond top-brass luncheon meetings.

2. Relationship with state licensing boards for nursing. Each state has its given set of regulations for the approval of nursing programs and for the licensing of graduates, which are administered by a state board of nurse examiners. The president of a college, as well as the chairman of a nursing department, is morally obligated to ensure that the student who successfully completes the college program will be eligible to apply for licensure within that state. Therefore, as stated by a Western region chairman, the college should seek consultation from the state board when the possible ADN program is but a twinkle in the college administrator's eye.

As revealed by the opinionnaires, problems with state boards are most evident: one-third of the nurse chairmen left this area completely blank, with no answer or opinion of any kind; one-third wrote the words "no problem" or "no comment"; and one-third gave suggestions they had found helpful in establishing relationships, such as inviting a board member to be an observer during a reasonable assurance visit by either NLN or a regional accrediting group; asking for assistance when establishing clinical field laboratories; providing a volume of information to document requests for change; through educational, political, and nursing circles, placing persons truly knowledgeable about associate degree programs on boards of examiners. R.N. licensing examinations and interstate endorsements of ADN graduates are issues or problems that must be resolved in the 1970's.

What key problems do these chairmen see continuing as programs evolve and new programs continue to develop?

1. Obtaining qualified faculty. Fifty-six percent of the group thought this the paramount problem. But they defined "qualified" as including no less than masters preparation for the core area or lead instructors (i.e., Fundamentals, Maternal-Child Nursing, et cetera). No ADN programs can be of quality with only teachers with B.S. preparation. For those teachers with masters preparation but no associate degree background and for instructors with B.S. preparation, attendance at ADN workshops should be mandatory. A necessary budget item of any department is planning for on- and off-campus continuing or committed education.

2. Inadequacy of clinical fields and need for regional planning for all nursing students. Only 41 percent of the group, but every region, was represented in making this the second major continuing problem. This problem offers a tremendous opportunity for joint involvement of college administrators and nursing educators--involvement in the form of broad regional planning for all health facility educational fields.

3. Financing. This is not a problem from the fund-seeking standpoint, but rather from the standpoint of justifying the cost of instruction. As one Middle States chairman stated, "As of this week, the honeymoon is over." A North Central director said, "Faculty-student ratios are now under fire." Five chairmen thought that the expansion required by college administration prior to sound program development created added financial stress.

   Last month, each of the six colleges of the university with which I am associated was responsible for developing a cost per credit study for each department. The Associate Nursing Department of the Junior College of Connecticut showed a cost of $60 per student credit (based on spring-fall 1968 total student enrollment of 79). Add to this $60 an estimated 30 percent overhead allowance, and the cost per credit comes to $85.70. Costs for other departments of the junior college were: Dental Hygiene, $70; Fashion Merchandising, $18.40; Secretarial Studies, $48. Based on the same computation, two science laboratory department costs in the liberal arts college were: Physics, $30, Biology, $24.70. Education for nursing is expensive. An accredited hospital school of nursing with an enrollment of 150 students, at today's prices, can easily have a net operating cost of $150,000 to $200,000 annually. As is stated by Blocker, Plummer & Richardson in the text The Two Year College--A Social Synthesis, "There is no doubt that the annual average expenditure of $550 per student in two-year colleges is much too low . . . for quality education, the cost per student should be in the neighborhood of $800 to $1,000 in comprehensive two-year colleges."[3] Experts on the cost of nursing and who should pay for nursing shall enlarge on this area tomorrow.

4. Rank of the department chairman. That this is a problem was made evident by one or two opinions from each area of the country. The problem concerned rank, place on the administrative level, and/or salary that did not equate with the administrative load. The February issue of the American Journal of Nursing ran nine ads for chairmen and faculty for new programs. Needless to say more on this area, but if diamonds are a gal's best friend, so are quality nurse chairmen the best friends of college presidents.

In closing, let's look briefly to the decade of the 1970's. Many problems associated with the implementation of ADN programs can be resolved if the concept of the program is properly researched by the college. AAJC's guidebook for program technology development and NLN's criteria or checklist for ADN program organization can't be beat. College administrators and nursing chairmen should seek consultation now available on a regional basis; visit quality programs in the area; spend a week or two at a major associate degree nursing demonstration center. Then, if properly researched and funded, and if time is given for potentially qualified faculty to plan a program, who says ADN history has to repeat itself?

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THE ALLIED HEALTH PROFESSIONS PROJECTS AT THE UNIVERSITY OF CALIFORNIA

Mary E. Jensen

The Allied Health Professions Projects at the University of California, Los Angeles, is a four-year program for curriculum development and creation of innovative approaches to education in the health-related occupations. It was initiated in August, 1968, by the Division of Vocational Education, University of California, Los Angeles, under a grant funded by the United States Office of Education.

Before I relate further details of the Project, I believe that it would be valuable for me to talk with you about the background information that contributed to its inception and development.

The Bureau of Research of the United States Office of Education noted, as many of you are aware, that statistics point to the fact that by 1975, conservative projections indicate there will be an additional requirement of over one million allied health workers. A detailed breakdown of the manpower required to meet these needs appears in the November 1968 Occupational Education Bulletin of the American Association of Junior Colleges.

There are, as you well know, great problems of information change and technological advance that create needs for continuing education for those already employed as well as make new demands on the institutions involved in preservice preparation of the workers. Community colleges are cognizant of these needs and of their responsibilities in preparing workers for the allied health occupations. Limitations of staff time and resources often hinder the quality and quantity of programs the colleges can develop.

The Office of Education believed that concentrated research and development drawing on the resources of community colleges, hospitals, and medical schools could make an impact on the preparation and validation of institutional systems in the allied health areas. After testing and refinement, the systems could be replicated in community colleges throughout the country--improving the quality of instruction and sparing colleges the cost of research and development of the system.

The U.S.O.E. staff, the Bureau of Health Manpower, the Public Health Service, and the Regional Medical Programs in the National Institute of Health identified the features that such a project should have. In February, 1968, the Office of Education invited the consortia of one or more community colleges, medical schools, and professional organizations to submit proposals for such a project. The programs to be developed were to have the following characteristics:

1. The areas for training should be chosen on the basis of national and local needs. They should be responsive to large and growing manpower requirements and to rapidly changing technological requirements. In other words, they should focus on the most pressing training requirements in terms of both personnel shortages and information change and growth.

2. The program should attempt to optimize the vertical and lateral articulation between courses of study.

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3. The program should be based on job or task analyses that clearly identify functions, duties, responsibilities, and skills required on the job and that indicate commonalities leading to a cluster or core approach to curriculum development.

4. The program should utilize the most current knowledge and technology related to the learning process. Appropriate use should be made of self-instructional techniques; the course should be individualized when possible; and the media and other instructional inputs should be validated in terms of their teaching effectiveness against specific performance specifications.

5. The programs in whole or in part should be capable of implementation in other community college institutions throughout the country with minimum adaptations.

Twenty-one proposals were submitted. The one prepared by the Research and Design group at U.C.L.A. was awarded a grant for the duration of four years. The objectives of the U.C.L.A. project are:

1. To identify by job or task analyses the curricula for a group of selected allied health occupations and to determine standards for required skills and knowledges for each, the occupations to be selected on the basis of national and local needs.

2. To develop innovative continuing education programs for each occupation, with maximum vertical and horizontal articulations, all based on the curricula and each including polysensory multimedia teaching materials packages.

3. To train teachers in the use of the new programs and materials in continuing (extension) classes by means of a series of national and regional teacher-training workshops.

4. To evaluate and improve the new programs and materials through controlled classroom and laboratory experiments in their use.

5. To develop and evaluate preservice education programs based on the curricula and innovative teaching materials prepared for use in the continuing education programs, and to train preservice teachers.

6. To develop and implement a procedure for maintaining the curricula and teaching materials current with changes and new research findings in the allied health occupations and to quickly incorporate these changes into the educational programs for those occupations.

A National Advisory Committee drawn from representatives of (1) educational institutions, (2) professional associations in the health field, (3) the public at large (foundations), and (4) public agencies (Veterans Administration) was selected to furnish counsel on broad policy and guidance in handling interagency relationships. The first meeting of the group was held September 13, 1968. Following that meeting, the occupational groups were identified for the U.C.L.A. project. They are:

1. Nursing.

2. Administrative and support service.

3. Radiation therapy.

4. Clinical laboratory.

5. Medical records, secretarial and assisting functions.

6. Bioelectrical examination and monitoring of patients.

7. Therapy and rehabilitation groups.

8. Social service and community-oriented occupations.

9. Opthalomogic/optometric occupations.

10. Dental occupations.

To date, associate project directors for all groups have been hired and are working on a full- or part-time basis. Technical advisory committees have been or are being named for each of these areas of the Project. The Nursing Advisory Committee was named and held its first meeting in Los Angeles on December 3-4, 1968. The associate degree nursing programs are well represented on this Committee by highly qualified nursing administrators and faculty. The members are:

Miss Georgeen H. DeChow, Chairman:
Director, Department of Nursing
Manatee Junior College
Bradenton, Florida

Dr. Hazle W. Blakeney, Chairman
Department of Nursing
Essex Community College
Newark, New Jersey

Miss Shirley L. Conklin, Coordinator
Registered Nursing Program
College of Marin
Kentfield, California

Dr. Betty L. Forrest, Chairman
Department of Nursing
Quinsigamond Community College
Worcester, Massachusetts

Mr. Gerald L. Griffin, Director
Department of Associate Degree Programs
National League for Nursing
New York, New York

Mr. William F. Hartnett, Assistant
Administrator for Nursing Services
Riverside Methodist Hospital
Columbus, Ohio

Mrs. Mildred Holloway, Acting Chairman
Department of Nursing
Los Angeles Valley College
Van Nuys, California

Mrs. Crystal Lange, Associate Professor
Department of Nursing
Delta College
University Center, Michigan

Mrs. Gerry White, Director
Nursing Education
Dallas County Junior College District
Dallas, Texas

The major purposes of the meeting were to recommend the ordering of priorities within the nursing cluster and to identify programs for which materials will be prepared. Those groups comprising the nursing cluster were selected. Those tentatively assigned to this area included: Registered nurse (professional), registered nurse (technical), licensed vocational nurse, operating room and obstetric technician, psychiatric aide, and nurses' aides and orderlies.

The committee members then ranked the occupations from high to low priority, with the following results:

1. Registered nurse (technical).
2. Orderly.
3. Nurses' aide.
4. Psychiatric aide.
5. Licensed vocational nurse.
6. Operating room/obstetric technician.

The committee also raised the following questions:

1. Where should the Project concentrate its time and effort to make the best use of resources? Where were the areas of greatest need?
2. Should the Project develop specific curricula as well as instructional materials? Should materials be developed so that they are usable in both preservice and continuing education programs? Should some materials be developed for students who require a longer period of time to complete a program?
3. How will the Project coordinate its activities with ongoing work in the field, such as that in the National Health Council and the American Association of Junior Colleges?
4. How relevant will the core concept of curriculum be to the development of instructional materials by the Project?
5. What influence will concerns about educational progression, i.e., the ladder concept, have on the development of educational materials?
6. Should the ANA Position Paper affect the setting of priorities for the development of curricula and instructional materials?
7. What is the role of the Nursing Advisory Committee? It was believed to be the following: (a) to guide the Project staff in selecting the health occupations to be included in the cluster; (b) to guide the Project staff in establishing priorities for the development of curricula and instructional materials within the cluster; (c) to review, on a continuing basis and at certain junctures such as at the completion of each step, the work of the staff as it carries out activities outlined for the Project.

The committee, after lengthy discussions, identified areas at the R.N. technician level that needed attention both in preservice and continuing education programs. The first of these was the area of maternal-child nursing. Problems in this area related to: (a) appropriate content, (b) lack of qualified faculty, (c) use of clinical facilities, (d) instructional materials, and (e) state board examination results. It was noted that an analysis might assist in identifying appropriate content, objectives, and expectations. The aspects common and unique to maternal-child nursing would be identified. It was pointed out that clearly defined objectives and appropriate materials would permit faculties to use these materials at those points where they believed the content should be

included. Materials could also supplement and reinforce content where clinical experience is difficult to plan or limited in quantity or quality.

A second critical area identified related to the concepts of interpersonal relationships, mental health, and mental illness. It was agreed that: (a) content, (b) clinical experience, (c) instructional materials, and (d) lack of prepared faculty were major concerns to most educational programs. This aspect of nursing, which related to all levels of practitioners, is also recognized as an area of critical need in hospital staff development programs.

As with content in maternal-child nursing, analysis would contribute to the identification of content unique to interpersonal relationships, mental health, and mental illness. Materials directly related to objectives would permit faculty to use these materials at those points where they believed the content should be included. Audio-visual media could be expected to contribute much to a student's learning, to faculty competence, and to nursing care of better quality.

Since that time, an initial draft of a functional analysis has been prepared and will be sent to the committee members for review and action. Refinement and validation of this analysis will continue. Professional research will be utilized in this as part of the work.

Other major tasks are to:

1. Assemble and review literature.
2. Select consultants.
3. Design dissemination programs.
4. Design evaluation programs.
5. Prepare institutional modules (materials) based on behavioral objectives.
6. Initiate design of research and development programs.
7. Orient faculties in use of materials.

Work with consultants, advisory committees, review of literature, and refinement of the occupational analyses are examples of continuing work essential to the Project. As it appears to me, the Project can and should be of great significance to all of the allied health occupations, including nursing. Personally, I am being challenged to discard many previously held notions regarding the questions we have considered at these meetings. Who shall be admitted? And how shall we prepare workers? We can no longer ignore career ladders, core concepts, or vestibule programs.* We must make it easier for people to learn. Education must be made available to more people at more times and in more places--in their personal lives and in the communities in which they live and work.

We have an opportunity--not only those of us directly working on the Project but, because of the Project's nationwide emphasis, scope, and committee representation, all of you--to become involved in a highly significant and relevant project. I believe the Project will contribute not only to the improvement of health care but also to more meaningful lives for more of our citizens. I enlist your commitment, support, and involvement in this Project.

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*This concept refers to developmental, or preparatory, programs.

THE PROFESSION'S INVOLVEMENT IN LEGISLATION

Helen V. Connors

In the kind of political system in which we live, organizations like the American Nurses' Association carry as one function, the promotion of legislation that will benefit its field and its members, speaking for them in regard to legislative action and promoting or opposing legislation and the actions of administrative agencies of government when these would, in the opinion of the profession, contribute to a lowering of standards.

This activity, described as lobbying, is the means by which we make our views known to those who make the laws and those who administer them Legislators, especially, need the services of this fourth arm of government, the lobbyists of the country. The nature of the problems legislators must deal with--all the way from a proposition for safe water to those involved in the tremendous technological and scientific advances that have pushed us into space--is such that no one member of the legislature can be an expert in them all. Therefore, they must turn to groups of people in society that have special kinds of knowledge and special kinds of interests.

In like fashion, staff in the administrative agencies of government need to have the assurance of a strong group in the private sector who will support them when they are subjected to pressures, from within and without, to lower standards and limit progress.

ANA has been involved in legislation since its beginnings, and in the early days, it concentrated most of its efforts on helping the state associations secure licensing laws--a first step in establishing some standards for nursing education and giving some assurance to the public that it could expect safe care. The Association is still concerned with licensing laws. After two days here, and attendance at other meetings of this Council, it's pretty obvious that you are, too.

Licensing of nurses came about because the leadership in nursing could not get voluntary acceptance of standards of education and turned to the state to impose them. In addition, in licensing, the state conferred a certain status on nurses.

All state laws were permissive, protecting a title only, into the 1950's. In the absence of an academic degree, the legal title, Registered Nurse, and the initials R.N. assumed an importance to many of us that carries over to the present.

Actually, the title and the initials, insofar as the state is concerned,if it acts legitimately in its regulatory function, simply indicate that an individual has successfully completed a state-approved program of study, passed an examination, and, therefore, is not likely to injure anyone.

In the early 1950's, ANA developed a model nursing practice act, which it recommended for use of state nurses' associations as they sought modifications in their state licensing laws.

The model act has four elements:

1. Defines nursing practice.

2. Establishes a board to implement the act.

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3. States certain procedures and criteria for licensure.

4. Denominates certain conduct as being in violation of the law and the sanctions to be imposed on those who are found guilty of violating the law.

At this time, three units in the ANA--the Commission on Nursing Education, the Council of State Boards of Nursing, and the Congress on Nursing Practice--are charged with looking at the model law and with making recommendations for change, which if accepted by the Board of Directors and/or the House of Delegates, the Government Relations Department, as the political arm of the Association, would work to implement.

The Council of State Boards of Nursing is very much aware of the questions being raised about the licensing examination. It needs funds to study it in terms of the beginning practitioner in nursing and has sought these funds without much success to date. In defense of the present examination: It is developed by item writers from the three kinds of programs that prepare for licensure as a registered nurse and is reviewed by all boards of nursing. Council members who are present can speak to the process better than I.

By the way, most other licensed groups tend to envy nursing because all candidates take the same examination and interstate endorsement is relatively easy.

Some questions relating to the purpose of licensure that we all need to be thinking about are, then:

1. Does the licensing examination test <u>more</u> than the knowledge needed to practice safely?

2. If a candidate needs X amount of knowledge to be considered safe, shouldn't we be pleased when candidates show by their scores that they have this knowledge, regardless of the program from which they were graduated?

3. Do we expect the examination scores to reveal the quality of education given? If so, isn't this something beyond safety? Is this the purpose of a licensing examination?

4. Do we expect the examination to reveal differences in types of programs in nursing? For example, should we expect graduates of baccalaureate programs to obtain higher scores, in safety of practice, than those from other programs? If so, are we attempting to measure something more than the knowledge needed to protect the public from unsafe practice?

I am confident that your thoughts, suggestions, and any complaints would be welcomed by the Council.

In addition to licensing legislation, the Association long ago spoke to certain national legislation that affected nurses, helping, back in 1901, to secure passage of a bill to create the Army Nurse Corps, <u>Female</u>. Somewhat later, in the 1950's, it finally secured recognition for men nurses in the Reserve in the Armed Services, working pretty much alone to break down this discrimination. Not until five years ago were men accepted in the Regular Corps.

ANA spoke also to national legislation that would provide a greater measure of health and security to the public, legislation dealing with maternal and child care, child labor laws, the social security system.

Major and steady growth in the legislative activities of ANA at the Federal level has occurred during the last 30 years just as Federal concern for the health, education, and welfare of people has grown and expanded.

In this country, we no longer think that the good things of life are simply desirable for all; we now think of these as within the reach of all, we think that everyone should have good health services readily available, that these services are a right and not a privilege.

At the national level, our government, over the past 10 years, has certainly been giving more than lip service to this belief by the enactment of significantly important education, health, and social legislation.

It was with the enactment of the social security system that our national government first became deeply involved in improving the lot of its citizens. Since its enactment, we have seen Federal funds going to the states to help them attack health problems, Federal funds being appropriated to help members of the health professions, especially physicians and nurses, take care of the preparation needed to deal with pressing public health problems.

The Second World War brought increased interest and funding for education in the health field, and after the war, interest continued for a time, but the momentum engendered by a great depression and a great war was somewhat slowed down in the 1950's, when we were becoming the most affluent society on earth.

The 1960's ushered in a new era and a new kind of thinking. In our affluent society, there were pockets of the most abject poverty. If we were to maintain our strength, our stability, and the promise of our country, then these newly recognized problems had to be dealt with.

There is now a basis for believing that everyone can, through choice and effort, obtain adequate food, clothing, and shelter and also gain an education, maintain positive health, and enjoy the satisfactions of the arts and of many other forms of wholesome recreation. Such a belief would have seemed utopian and visionary a decade or so ago.

In the middle of December, the Secretary of the Department of Health, Education, and Welfare, Wilbur Cohen, sent a report to President Johnson stating the legislative accomplishments of the last five years in the fields of health, education, and welfare. Regardless of one's political affiliation, the accomplishments in these areas under the Johnson Administration must be recognized as very substantial. It should also be said that support for these social programs, and especially those relating to the preparation of health manpower, has been bipartisan. In both political parties, nursing has had friends, and from both, support.

When I say we have had friends and support, I do not necessarily mean that every enactment has been perfect and reflects everything the American Nurses' Association considers desirable. Politics is the art of the possible. The legislators who make our laws, at whatever level of government, are subjected to pressures from many interested groups. They try to achieve a balance, arrive at a compromise they hope will satisfy all the groups involved.

Let me digress here to say that policies adopted by elected officials (the Board of Directors) and the House of Delegates become ANA's official position. In the Association, these policies are arrived at with the greatest amount of membership participation possible.

Delegates from each state are elected from the various occupational groups. Issues to be discussed are circulated beforehand. When issues are presented, SNA members may instruct their delegates how to vote or may permit them to use their own good judgment, which is the more desirable practice. Issues usually grow out of commission or committee action, and commissions and the committees comprise members who are appointed and elected. Suggestions for candidates for officers and for commission and committee work are solicited from the state nurses' associations.

Policies and programs are determined according to needs of nurses and nursing and the people they serve. Individuals within the Association may at times find themselves in opposition to a policy of the Association. This is an individual right. But it is the responsibility of members to support a policy determined by the majority of the members when they speak or act for the Association. Nothing would confuse legislators more than 200,000 opinions about an issue facing nursing.

One of the characteristics of a profession is that of self-determination. In certain matters, the profession, as the expert group, speaks for itself. Perhaps no group has had as much difficulty attempting to be self-determining as nurses. Over the years, vested interests and well-meaning groups have consistently expected and demanded the right to participate in decisions relating to nurses and nursing. Areas in which the problems are most acute are those of licensing legislation, economic security, and education.

There are other issues, too, in which nurses may have difficulty in establishing themselves as the official spokesmen for nurses. It is not uncommon for groups working in the same general field to have different opinions on certain issues. This I am sure you know only too well. But knowing your opposition can help you overcome it or at least deal with it.

Once policy relating to legislation is determined, the ANA Government Relations Department plans, directs, coordinates, and evaluates the Association's working relationships with government agencies and its promotion of legislation.

The Department's responsibilities are to study trends in government for their implications for nursing practice, services, education, economics, and for the goals of ANA; to monitor Federal, state, and municipal legislation and the actions of administrative agencies; to interpret governmental developments to appropriate departments and programs of the Association; to devise, conduct, and evaluate the promotion of legislation to further the programs of the Association; and to facilitate communication between the respective program areas of ANA and the appropriate government agencies.

The program of the Government Relations Department evolves from the program adopted through the platform of the Association, other action taken by the House of Delegates, and recommendations or policies formulated by the ANA Committees, Commissions, and the Divisions on Practice. Some of the policies or recommendations can be attained directly by legislative action, others partially fulfilled, and still others accomplished through the agencies of government without specific legislation. What we do at any given time is determined by the urgency for action, the political climate, and the effect on the long-range goals of the Association. You might describe the Government Relations Department as the expeditor of those Association programs that call for political action.

We are not a large department of ANA. There are two staff members in New York and three authorized positions in Washington. Considering the volume of Federal legislation that impinges on nurses, nursing, health, and welfare, it became evident several

years ago that some system of priorities was needed to guide the total legislative effort of the Association. You see, in addition to the action program at the national level, the staff in New York is committed to assist and advise the state associations as they conduct their legislative programs.

Success in legislation depends upon planning and carrying through extensive educational activities. Often, these must be carried on over a period of years, before results are seen in terms of legislation in a specific area of the Association's interest. These long-range aspects of the program, coupled with the essential day-to-day operations of promoting or opposing measures of immediate concern to legislative bodies, are costly in terms of money and the time of staff, consultants, and members of the commissions, committees, and divisions who are directly involved. It was determined, therefore, that it was neither possible nor wise to expend a like amount of energy and funds on each area of the program.

Greatest effort nationally has been given, and is still being given, to securing Federal support for nursing education. This is not a new priority--it goes back to World War II and the Cadet Nurse Corps; to support of the G.I. Bill of Rights, which helped nurses undertake additional study; to the graduate nurse and public health traineeship programs of the 1950's.

After the enactment of the traineeship programs, the ANA Committee on Legislation considered that the next major effort should be directed to securing aid for baccalaureate programs in nursing. The rationale for this was that if we were to have increased enrollments and to increase nurse manpower and insure quality practice in the years ahead, the pool of nurses holding baccalaureate degrees had to be enlarged. It was from such a pool that you would draw nurses into graduate programs to prepare for teaching, administration, supervision, and specialized clinical practice. Without sufficient numbers of these personnel, programs could not expand significantly nor could patient care be improved.

We were able in 1958 to get some members of Congress to introduce legislation that proposed construction grants and instruction costs for nursing schools in colleges and universities and scholarships for students entering such programs. We did not anticipate immediate and favorable Congressional action. For one thing, this was not Administration-backed legislation, and we can safely say that, generally, unless the Executive Branch has initiated a proposal, the Legislative Branch is not likely to act on it. However, it was a device we used to call to the attention of legislators and the public the critical need for nurses and the critical need for financial aid to nursing education.

Six years later, as you know, the Nurse Training Act was passed. While it was not all we would have wished, it was the most significant financial assistance that basic nursing education had received. There was no provision for scholarship aid then, but in 1966 the Act was amended to include educational opportunity grants. Its extension last year as Title II of the Health Manpower Act was certainly welcomed.

At the time the Nurse Training Act was passed, we not only saw its design as one to increase the supply of nurses but believed also that the intent of Congress was to insure quality education by requiring that only nationally accredited nursing programs would be eligible to apply for Federal funds. That evaluation and accreditation of nursing programs made by members of the profession provided the best assurance that the programs would produce competent practitioners and that the public, recipients of the services, would be well served is a long-held position of ANA.

While the Association worked for the enactment of nursing practice legislation in the states as an effective, expedient means of establishing and maintaining minimum standards for the preparation of nurses, it recognized that legal standards are minimal and that they vary from state to state just as standards for general education vary.

Had nurses been satisfied that legal standards were sufficient, there would have been no movement toward national voluntary program accreditation. But the need for standards above and beyond those required by law was acknowledged by the profession itself.

We were, of course, committed to oppose change in the accreditation provision of the Nurse Training Act when change was proposed in 1965. We had some success. However, last year, with the enactment of the Health Manpower Act, we were not successful in spite of active lobbying. The Commission of Education may now name, in addition to the national accrediting body, regional accrediting bodies and state agencies.

The Office of Education has now published its criteria for recognition of state agencies for approval of nurse education. When the criteria were being developed, the ANA Council of State Boards of Nursing was asked to review them and comment, and they do reflect suggestions made by the Association. According to the Federal Register of February 28, no state agency has yet been named by the Commissioner.

Of special concern to ANA at this time is the budget request of the last Administration to implement Title II of the Health Manpower Act. When Congress passed this legislation, it authorized certain funds for each provision of the Act except scholarships, for which a formula for grants was proposed. When Congress authorizes, it puts a ceiling on the amount that can be requested.

However, the Administration request for appropriations is well below the authorizations. For example, $25,000,000 is authorized for construction grants, but only $8,000,000 is asked for. There is no request for institutional grants (basic support grants), which have been available to diploma programs but were to be extended to baccalaureate and associate degree programs under the new Act.

The steps we are taking to bring appropriations more in line with authorizations are to:

1. Visit those members of Congress who are on the subcommittee that hears testimony on appropriations for the Department of Health, Education, and Welfare.

2. Request schools in the congressman's district to provide him with information about their needs and the needs of students.

3. Ask state nurses' associations to provide information on over-all state needs.

4. Present ANA's testimony before the subcommittee during hearings.

5. Ask all state nurses' associations and all schools of nursing to support or oppose (depending on what comes out of the Appropriations Committee) when the legislation goes to the floor for debate.

I would like to thank all of you who have helped us in our political efforts in the past. I hope we can continue to count on you in the future.

WHO SHOULD PAY FOR NURSING EDUCATION?

Mildred Montag

On the face of it, the question of who should pay for nursing education seems simple to answer--it seems that the "how" might be more difficult. On further reflection, the first question is deceptively simple, however. At least this is how it appeared to me at first when I agreed to discuss the question on this panel. The problem then seemed to me to be how to make enough of it to prepare a paper suitable for a program like this. The more I thought about it, the less clear the question became. The word should implied that there might be a choice as to who or what groups should. It also implied that someone has been paying. Finally, the question divided into three questions rather than one, and so I shall attempt to deal with the three questions as I see them.

The first question is who has paid for nursing education in the past; the second, who should pay; and the third, who will pay. I shall discuss each in turn, for they are stated in terms of ascending importance.

Who has paid for nursing education? The question of financial support of nursing education has been a problem virtually from the beginning of what we know as modern nursing. Florence Nightingale's school at St. Thomas Hospital in London was begun as a result of a gift of about $200,000 to Miss Nightingale in grateful recognition of her work in the Crimean War. Although the first schools of nursing in the United States were independent schools, they lacked money from the beginning and were the recipients of no such bounty as St. Thomas School of Nursing received. It was not until 50 years later that Helen Hartley Jenkins made a substantial contribution to Teachers College, Columbia University, for the program developed there for graduate nurses. The program at Teachers College was begun and continued for several years because nursing leaders contributed the necessary money. In fact, the program at Teachers College was contingent upon the receipt of money to support it. These nursing leaders provided the funds, usually out of their own pockets. Miss Nutting put the problem this way:

> The primary function of all training schools is that of carrying on the regular nursing work of the hospital. It is not anywhere the education of the nurse. That education is the subsidiary, secondary, purpose of the hospital in establishing a training school, and it follows, as a matter of course, that it can be carried out only in so far as is compatible with the main purpose of nursing the patients through the students of the school.[1]

She further observed that schools and colleges were usually supported by taxation, gifts, and tuition and fees. She noted that state systems of education were developed to implement educational programs from the elementary grades to professional schools. In fact, she said,

> . . . one is inclined to believe that the need for training, in almost any direction promising useful

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> service to the community, has only to be recognized to ensure it a place in the concern of the state, or to bring it definitely within the scope of state responsibility.[2]

She also quoted the Secretary of the Carnegie Foundation as stating that "Present educational demands, upon even a modest college . . . require resources of approximately a million dollars."[3] (This in the early 1920's.) Miss Nutting then quickly noted:

> You will not find one single gift of any appreciable amount, not one endowment placed at the disposal of the training school for nurses for the proper conduct of its educational work.[4]

All this prompted Miss Nutting to conclude in 1926 that

> The root of all the main problems in nursing will be found, I believe, if carefully studied, to be economic in nature.[5]

Some 20 years later, Petry wrote an article titled "Who Pays for Nursing Education?" She stated that the schools that were operated by hospitals had their funds and the hospital funds "inextricably" merged. This was also true of university schools, particularly in the clinical portion. She listed the chief sources of income for a school of nursing as tuition and fees, endowment and gifts, and nursing service to hospitals. When these sources proved insufficent, hospital funds were tapped, and this meant that patients' fees, endowments and gifts, and tax money if a public institution, were used to supplement the school's funds. It was also true that when the income exceeded the cost, the excess went into hospital funds. Petry concluded that

> In terms of persons, then, we have as sources of income to the school of nursing, the student nurse, always; the giver of large and small gifts, sometimes; the patient, sometimes; the taxpayer, sometimes.[6]

In the USPHS study Petry was reporting it was found that 97 percent of the income of the schools of nursing came from the students themselves, with 83 percent calculated as income from student services.[7] She also stated that

> It is possible that in some instances this /value of student services/ is more than 100 percent of the total cost of her education and maintenance.[8]

She sums up the problem thus:

> Our inability to say how much nursing education costs, is no less regrettable than the fact that those who pay it do not know how much they pay, or in many cases that they are paying at all, while those who are potentially eager to pay do not know of their opportunity to pay.[9]

These few reminders of our past with respect to financing nursing education will serve to show us how confused the picture has been. It is clear that the student in nursing programs has borne a disproportionate share of the cost of her education. That the patient has subsidized, in part, the cost of nursing education is also clear. Various figures have been given as to the added cost per patient day in hospitals offering a nursing program.

These programs with respect to the financing of nursing education led us to set as one criterion for participating in the Cooperative Research Project in Junior and Community College Education for Nursing the following:

> The institution must be willing and able to provide and pay for the new program in nursing.[10]

Because those in the Project were willing and able to and did, in fact, develop and maintain their nursing programs from college funds, we were able to draw the following conclusion:

> Junior-Community Colleges have found it possible to finance these programs within the financial structure of the institution.[11]

This seemed to be as important a conclusion as any in the total study, for up to that time the baccalaureate programs were still dependent on hospital support for at least the clinical portion. It is only in recent years that they, too, have been financed by the institution of which they are a part.

Associate degree nursing programs have continued to be supported financially through whatever sources the colleges provide. The 1968 Facts About Nursing makes the following statement:

> The advent of the associate degree program is largely responsible for bringing nursing education more into the public support sector. Almost 92 percent of the schools under the administrative control of junior or community colleges were largely under public auspices as were 55 percent of the schools controlled by universities or senior colleges in 1967.[12]

It might be fair to add that the financing of associate degree nursing programs by the colleges facilitated the financing of baccalaureate nursing programs by their respective institutions.

It seems obvious that the answer to the question, Who has paid for nursing education? is different somewhat from the question, Who is now paying?

Who should pay for nursing education? is the next question. Esther Lucile Brown took the position that nursing was an essential social service and that everyone in the society should be concerned about it. If one accepts this position, then one must answer that all of society should pay for nursing education. This would seem to me to include both the public and the private sectors of society.

It is obvious that the increase in colleges, junior and senior, and universities in recent years has been in the public sector. Doermann in his new book, Crosscurrents in College Admission, states:

> As recently as 1950, half of the nation's college students were enrolled in private or church-related colleges. By 1965 the ratio of enrollment in private colleges /as compared to/ public institutions was only one-third to two-thirds. Projections made by the Fund for the Advancement of Education in 1963 estimate that by 1985 the ratio may be something like one-fifth private to four-fifths public.[13]

It does seem to me that the privately supported college has made too significant a contribution to be lost as we contemplate the future of education and how it can be supported. It would seem only logical, then, that nursing programs would also be found in private institutions. The provision of financial aid to students wishing to attend private institutions should be encouraged. Again, I would include nursing students in such financial aid. It is interesting to note that large gifts to nursing schools are infrequent if not entirely missing. Endowed schools of nursing are but a hope, not a reality. In this, the picture Nutting portrayed in 1926 is still accurate.

Perhaps a word should be said about who should not be expected to pay for nursing education. The hospitalized patient should not be expected to bear the cost of nursing education as he has in the past. It is well known that illness is more prevalent among the aged and the poor, surely the wrong groups on which to inflict an added burden.

In short, then, my answer to the question, Who should pay? is that the total community, all of society, should pay for nursing education, for it is the total community that will benefit from the services that nursing students are being prepared to give. Both the public and the private sectors share this responsibility.

The last question, Who will pay? is perhaps the most significant of all three. One could present a strong case for the obligation of all society to pay based on a history of neglect, but in the last analysis the public, the citizen, will determine what his money will be spent for.

The public will pay for nursing education if certain conditions prevail. It will pay if:

> The service it receives from those educated is of high quality.
>
> The service it needs from these persons is in sufficient quantity.
>
> The service to be rendered is available when and where it needs it.
>
> The cost of the service is reasonable.
>
> The cost of the education is based on reasonable requirements as to facilities and faculties.

If these conditions are not met, the public may well withhold its support. We have evidences of school budgets' being rejected by a community, even to the point of closing the schools for a portion of the year. The idea that schools or colleges can simply go to the public for more money whenever they wish more is not realistic.

What does all this mean to associate degree nursing programs? Let me list a few of the implications as I see them.

> We cannot afford ineffective teaching that only partially prepares the student for the work he is supposed to do on graduation.
>
> We cannot afford unrealistic teacher-student ratios that keep programs smaller than they should be.

We cannot afford ill-planned and ill-executed curricula. Some programs are attempting to do what baccalaureate programs should do. Clear objectives for both the entire curriculum and the several courses therein are mandatory.

We cannot afford the wholesale loss of students once admitted through inadequate programs of evaluation.

We cannot afford the luxury of large numbers' failing to pass the licensing examinations.

We cannot afford to hear reports that associate degree nursing program graduates do not know how to, or do not give, good nursing care.

The associate degree nursing programs cannot do less than produce graduates capable of giving quality nursing care through curricula carefully conceived and implemented, taught by prepared, committed faculty. If they do this, the public will pay.

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7. Ibid., p. 829.

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10. Mildred Montag. Community College Education For Nursing. New York, McGraw, 1959, p. 29.

11. Ibid., p. 340.

12. Facts About Nursing. New York, American Nurses' Association, 1968 ed., p. 104.

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NEW CURRICULUM DEVELOPMENTS

Patricia A. Hyland

Our interest this morning is in looking at new developments that are being made in curricula. As a representative of the faculty of Nassau Community College in New York, I am pleased to share with you some of our thinking. When we started our curriculum change, we called it "changing the second-year course." I now understand that we have an "integrated curriculum"!

I believe, it goes without saying, that the development of curriculum is an ongoing, united effort of the total faculty. In its dynamic nature, it has a past, a present, and, if vital, a future. We have been fortunate at Nassau to have a well-prepared, hard-working faculty. We have been fortunate also in our historic development. We owe a debt to past faculty, and in particular to Dr. Ruth Matheney, who, after establishing two other associate degree programs in nursing, initiated our program in 1962 and who, until 1968, played a vital role in the development of our total program.

The initial curriculum pattern was what one might now call traditional for ADN programs.

> /Editor's note: At this point, a transparency of the 1962 curriculum outline was projected for the audience's information, which was followed at intervals by transparencies illustrative of or supplementary to various references to the curriculum and its further development made by the speaker. For the materials displayed, see appendix to this presentation./

The focus of the four semesters in nursing and the related use of clinical facilities were as follows. /Transparency No. 2./

In 1964, a somewhat minor revision was made in the second-year nursing courses. As shown /Transparency No. 3./, the title of the fourth semester became "Nursing Care in Long-Term Health Problems." The use of clinical facilities remained substantially the same. Students were assigned to clinical experience, and the content was presented in isolated blocks of obstetric, pediatric, psychiatric, and medical-surgical nursing.

I believe that in many of the past council meetings, adequate discussion has taken place concerning our educational philosophy in the preparation of the technical nurse, on the utilization of the 21 nursing problems, on problem-solving, as well as on the selection of experiences ranging from the simple to the complex and the use of pre- and post-conferences. I mention these now as an integral part of our philosophy, which we still hold and which still forms the basis of our curriculum.

By 1966, the faculty wished to effect changes in the second year that would:

1. Aim at a greater integration of specialty areas into the total and thus eliminate blocks and fragmentation of content.

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2. Emphasize complexity in patient care and the interrelatedness of nursing problems.

3. Allow for the progress in depth while building on past learning.

4. Provide for better articulation of the second-year curriculum with the first-year curriculum.

In order to achieve these objectives, the faculty developed broad generalizations, or basic concepts, from which the total of the second year would evolve and within which all specialty areas and related clinical facilities could be represented. Here are the basic concepts. /Transparency No. 4./ These concepts are obviously not unique to us, but we have brought them together as our first unit of study in order to set the stage for the approach to the total second year.

As we look at the outline of the orientation unit /Transparency No. 5/, it would appear that many of the items have already been included in the first year. In many instances it is true that a beginning thread did appear then, but now these threads are picked up to be elaborated upon and woven throughout the following semesters.

In respect to the first instance--a unified concept of health and disease--students in the first semester have examined the definition of health as presented by the World Health Organization, and they have had experience with patients with specific disturbed physiologic processes. With this introduction we present a concept of health and disease as described by George L. Engel in his contribution to Life and Disease, a Basic Book, edited in 1963 by Dwight J. Ingle. In understanding that man acts as a unit, Dr. Engel points out, "Health and disease are not static entities but are phases of life, dependent at any time on the balance maintained by devices, genically and experientially determined, intent on fulfilling needs and adapting to and mastering stresses as they may arise from within or from without."

Stress as discussed in this unit includes past learning, stress or anxiety as it affected students' behavior, in relation to the patients' reaction, psychosomatics, and Selye's concept of stress. Again leaning heavily on George Engel, we look more specifically at those factors that cause stress.

1. Factors that cause stress by virtue of their physical and/or chemical properties, both internal and external.

2. Physical factors that may be insufficient or unavailable.

3. Factors that stimulate the body's rejection mechanism.

4. Psychological factors that produce stress.

In discussing adaptation, we refer to Rene Dubos' works, Man Adapting and Mirage of Health, and to Irene Beland's Clinical Nursing: Pathophysiological and Psychosocial Approaches. We have defined within this area levels of adaptation. Although each level is somewhat artificial in nature, they are directed toward helping the student to plan for the scope of medical, but particularly nursing, intervention that would promote a higher level of wellness for her patient.

The awareness of critical times in the life cycle of man allows us to discuss the significance of stress and an individual's response at various stages of development, such as prenatally, during adolesence, or with aging.

Since the individual is a social being, group functioning is included. Discussion included a group as a stress, as a positive or negative factor in adaptation, and the utilization of in-hospital or outside groups for the individual's well-being.

Items B and C of the orientation unit provide avenues for trying learning from science, sociology, child development, and psychology and emphasizing their relationship to health patterns.

Finally, the summary of intervention includes all those areas that may be put into use in accordance with the individual's level of adaptation.

Following the orientation unit, the plan of the second-year unit outline /Transparency No. 6/ shows a grouping of nursing problems. Unlike the first year, during which nursing problems are studied individually, this plan allows for the focus on the interrelatedness of nursing problems. Hopefully, this moves the student from the analysis of individual problems to a synthesis phase. We have found that students are better able to anticipate changes in a patient's condition and to make a care plan that is directed toward assisting him to a higher level of wellness or adaptation.

At the beginning of the last semester, we pick up a thread on group therapy in order to highlight primary and secondary groups and the part they may play in a person's adaptation. We expect the student to include these groups in her immediate care plan as well as to utilize them in meeting long-range goals of her patient.

The concluding unit, "Changing Patterns of Health Care and the Resultant Change in the Nurses' Role," allows students to discuss changes that are now affecting and will later affect their patient care. In some instances, we can only assume the future impact of technologic change.

I should like, for just a moment, to show you two excerpts from the instructor's content outline. /Transparencies Nos. 7 and 8./ The examples of diseases or pathologic changes are those suggested areas that the faculty has chosen as representative topics to be included in discussion. Unfortunately, a limitation of time does not allow for elaboration on this, but I might point out that the examples tend to interweave clinical specialties. They also allow for inclusion of patients of all ages.

In the initial planning of the integrated content, all members of the faculty played a part. Specialists in psychiatric nursing, maternal-child nursing, and medical-surgical nursing played a major role. In the presentation of the course, we use a team-teaching approach. For a class section of 30 to 35 students, three faculty members form a team. Each of these instructors represents a specialty. All three instructors plan the classes, and all attend class. Each instructor presents the content related to her specialty, and all take part in discussion.

For clinical experience, students are subdivided into three clinical groups of 10 to 12 students each. As the following transparencies show /Nos. 9 and 10/, students receive experience in multiple settings at the same time. They are in each of the specialty areas with the pertinent instructor for that area.

A preconference is held by each instructor and her small group. The same predetermined broad focus is set in each group for the day's experience. After the experience, the total class is brought together for a postconference so that a sharing of experiences will pick out those commonalities and differences that are present.

As a review, in conclusion, I should like to show you this transparency /No. 11/. Our curriculum now moves from broad generalization relative to health to specifics related to disturbed physiologic processes. We go on in the second year, based on an approach of stress and adaptation, to the interrelatedness of nursing problems, including

depth of content, and utilize all facilities in the hospital or outside that do contribute to the individual's health--in prevention of disease, maintenance of health, or the rehabilitation process.

In view of the ongoing nature of curriculum, we can foresee that these changes in our second year will have some effect on the content of the first. We can also foresee changes in the use of facilities in the first year.

It is our hope that this survey of our work will stimulate others and that in your comments, we, also, will benefit.

APPENDIX NO. 1. ORIGINALS OF TRANSPARENCIES

1962
NURSING MAJOR
LEADING TO THE ASSOCIATE IN APPLIED SCIENCE DEGREE

FIRST YEAR

1st Semester

CODE		COURSE	HOURS PER WEEK CLASS	LAB	CREDITS
ENG	101	Composition and Rhetoric	3	-	3
BIO	103	Human Biology	3	3	4
SS	201	Principles of Sociology	3	-	3
NUR	101	Fundamentals of Nursing	4	-	4
		Elective in Humanities	3	-	3
			16	3	17

2nd Semester

ENG	102	Composition and Rhetoric	3	-	3
BIO	104	Human Biology	3	3	4
SS	202	Principles of Sociology	3	-	3
NUR	102	Fundamentals of Nursing	8	-	8
			17	3	18

SECOND YEAR

3rd Semester

BIO	214	Microbiology	3	3	4
SS	203	General Psychology	3	-	3
SS	213	Child Development	3	-	3
NUR	201	Maternal and Child Care	9	-	10
			18	3	19

4th Semester

SS	204	General Psychology	3	-	3
NUR	203	Care of the Mentally and Physically Ill	9	-	9
		Elective in Humanities	3	-	3
			15	-	15

TOTAL CREDITS REQUIRED 68

NO. 2

SEMESTER	FOCUS	CLINICAL FACILITY
FIRST Fundamentals of Nursing I	Broad generalizations relative to health and the presence of Stress "Normal" Problems 1-5 of "Nursing Problems"	Community agencies Medical and Surgical Out Patient Department
SECOND Fundamentals of Nursing II	Specifics related to disturbed physiological body processes, oxygen, fluid and electrolytes, nutrition, elimination, regulatory. Include Long Term Illness and Emotions.	Medical and Surgical Out Patient Department - Recovery - ICU Rehabilitation
THIRD Maternal and Child Care	"Nursing Problems" as they relate to Maternal and Child.	Obstetrics and Pediatrics Related hospital facilities-OPD Related community facilities
FOURTH Care of the Mentally and Physically Ill	"Nursing Problems" Stress on emotional including long term illness	Psychiatry Medical and Surgical Rehabilitation Related community agencies

No. 3

1965
NURSING MAJOR
LEADING TO THE ASSOCIATE IN APPLIED SCIENCE DEGREE

FIRST YEAR

1st Semester

CODE		COURSE	HOURS PER WEEK CLASS	LAB	CREDITS
		Orientation	1		0
ENG	101	Composition I	3		3
BIO	107	General Biology I	6		4
SOC	201	Principles of Sociology I*	3		3
NUR	101	Fundamentals of Nursing I	8		4
			24		17

2nd Semester

ENG	102	Composition II	3		3
BIO	108	General Biology II	6		4
PSY	203	General Psychology I*	3		3
NUR	102	Fundamentals of Nursing II	16		8
			28		18

SECOND YEAR

3rd Semester

BIO	214	Microbiology	6		4
PSY	213	Child Development	3		3
NUR	201	Maternal and Child Health Nursing	18		10
			27		17

4th Semester

SOC	203	Cultural Anthropology	3		3
NUR	202	Nursing Care in Long-Term Health Problems	18		10
		Elective in Humanities	3		3
			27		17

TOTAL CREDITS REQUIRED 68

*PSY 203 may be taken in the first semester, SOC 201 in the second semester.

No. 4

BASIC CONCEPTS:

1. Unified concept of health and disease.

2. Stress and adaptation as they relate to health and disease.

3. Interrelatedness of nursing problems and health problems.

4. Promotion of positive health and the prevention of disease.

No. 5

NURSING 203
COMPREHENSIVE NURSING CARE I

UNIT I - Orientation to Second Year

A. Basic Concepts
   1. Unified concept of health and disease
   2. Stress - Anxiety
   3. Adaptation (degrees of effectiveness)
      a) Concepts
         1. Range on a continuum
         2. Varying levels in same individual
         3. Interrelatedness of categories of all levels
         4. Dynamic mobility from one level to another
      b) Levels
         1. Maintenance of homeostasis without undue effort
         2. Maintenance of homeostasis with effort required
         3. Damage or loss at any level of organization which requires development of compensatory adaptive mechanisms
         4. Compensatory adaptive mechanisms as a problem
         5. Total decompensation
   4. Concept of critical times
   5. Group functioning

B. Factors that influence health patterns
   1. Genetic
   2. Congenital
   3. Family (primary group - role identification)
   4. Socio-cultural (secondary group)
   5. Developmental tasks
   6. Environment
      a) External (Pollution - overcrowding - technologic changes)
      b) Internal (Disease)

C. Significance of emotional stress factors for health and disease
   1. Psychological development
      a) Problems in role identification
      b) Loss of significant figures
   2. Patterns of behavior

D. Summary of intervention
   1. Research
   2. Maintenance and promotion of health
   3. Therapies
   4. Rehabilitation
   5. Nursing
      a) Physical care
      b) Emotional support
      c) Observation
      d) Treatment
      e) Teaching
      f) Counseling
      g) Economic consideration
      h) Complex correlation(interrelatedness of 21 problems)

No. 6

Unit Outline

First Semester - 2nd Year

Unit I - Basic Concepts

II - Nursing Care of Patients with Regulatory, Sensory, and Motor Problems

III - Nursing Care of Patients with Oxygen Problems

Second Semester - 2nd Year

Unit I - Nursing Use of Group Theory in relation to the Individual and the Community

II - Nursing Care of Patients with Fluid and Electrolytes, Nutrition, and Elimination Problems

III - Changing Patterns of Health Care and the Resultant Change in the Nurses' Role

4. Observation of changes in neuromuscular function in response to stress
   a) Central Nervous System
      1. Cerebellum
      2. Extra pyramidal tract (encephalitis)
   b) Lower Motor Neuron
   c) Neuromuscular Junction (anesthesia)
   d) Muscle
   e) Implications for nursing intervention
5. Nursing intervention based upon pathological adaptations to stress
   a) Central Nervous System
      (hysteria, catatonia, schizophrenia, vascular disease, tics, infections, tumors, trauma, demyelinating disease, hereditary disease, subacute combined degeneration)
   b) lower motor neuron
      (polio, peripheral neuritis, herpes zoster, myelitis, disc, diptheria, diabetes, periarteritis, mononucleosis)
   c) neuromuscular junction
      (myasthenia gravis, High Ca, K, Na, Mg)
   d) muscle
      (anesthesia, tubocurare, infections and debilitation, disease of endocrine glands, muscular dystrophy, primary and secondary uterine inertia)

D. Nursing Care of patients with central nervous system problems

1. Persons with varying levels of consciousness
   a) awareness of stress factors which alter levels
      1. physiological
      2. psychological influencing physical
   b) observation of levels of consciousness
   c) nursing intervention based upon pathological responses to stress
      1. primary factors (intracranial)
         (vascular, infection, neoplasms, seizures, severe intracranial pressure, neurosis, psychosis)
      2. secondary factors (extracranial)
         (arterial hypertension, hypertensive encephalopathy, metabolic disorders, hypoxia, asphasia, systemic disease with involvement)
      3. traumatic - chemical etc.
         (trauma, electric shock, hyperthermia, hypothermia, intoxication, hallucinations, delusions, fear)
2. Persons undergoing sensory changes
   a) health education, supervision and support
      1. physiology of aging
      2. psychological aspects
   b) awareness of stress factors as they influence sensory change

UNIT III - Nursing Care of Patients with Oxygen Problems

A. Awareness of activities and alterations of pulmonary circulatory systems during critical periods of development
   1. Adult
   2. Maternal cycle (diaphragm pressure in 8th month, placenta-uterine contractions, labor-breathing techniques)
   3. Fetal - Film "Age Minus 60 Days"
      (cause of first breath, physiological jaundice)
   4. Aging
      (normal changes - puberty, heart murmur, anemia in girls)

B. Stress factors and preventive aspects
   1. Inflammatory
   2. Neoplasms
   3. Congenital
   4. Genetic
   5. Vascular
   6. Traumatic
   7. Environmental (too much or too little available oxygen)
      (carbon monoxide poisoning, retrolential fibroplasia)

C. Health education, supervision, and support of persons in relationship to stresses encountered

D. Awareness of general symptoms as adaptive response to stress

E. Awareness of pathologic physiology adaptation and related specific nursing intervention
   1. Impaired ventilation
      a) Restrictive defects
         1. decreased strength of muscle tone (polio, fx. rib, multiple sclerosis, myasthenia gravis, paralysis)
         2. limitation of inspiratory capacity
            (a) limited rib motion (rheumatoid spondylosis, ankylosis)
            (b) limits descent of diaphragm (ascites, pregnancy obesity)
         3. encompassed and constricted lung caused by scar tissue or fluid in pleural space (empyema, hemothroax, rt. sided failure, pleurisy)
         4. stiffening of the substance of lung with scar or edema fluid (T.B., tumors, lung abscess, pneumonia, occupational hazards)
         5. loss of lung substance (decompensated heart disease, mitral stenosis, cardiac insufficiency, tumor, abscess, T.B.)
      b) Obstructive defects - narrowing of tracheobronchial tree (aspiration, foreign body, polyps, thickened secretions, mucus (baby) (cystic fibrosis), tumors, strictures, asthma, emphysema)

No. 9

NURSING 203

CLINICAL EXPERIENCE - CLASS SECTION AA - 30 STUDENTS

DATES	GROUP 1 10 Students	GROUP 2 10 Students	GROUP 3 10 Students
September 17	Psych	OB	Surg
September 19	Psych	OB	Surg
September 26	Psych	OB	Med
October 1	Psych	OB	Med
October 3	Psych	OB	Med
October 8	Psych	OB	Med
October 10	Surg	Psych	Med
October 15	Surg	Psych	OB
October 17	Peds F.T.	Psych	OB
October 22	Peds	Psych	OB
October 24	Peds	Psych	OB
October 29	Peds	Psych	OB
October 31	Peds	Med	OB
November 5	Peds	Med	Psych
November 7	Peds	Med	Psych
November 12	Surg	Peds F.T.	Psych
November 15	Surg	Peds	Psych
November 19	Surg	Peds	Psych
November 21	Med	Peds	Psych
November 26	Med	Peds	Surg
December 3	Med	Peds	Surg
December 5	Med	Peds	Surg
December 10	Med	Med	Peds F.T.
December 12	OB	Med	Peds
December 17	OB	Surg	Peds
December 19	OB	Surg	Peds
January 2	OB	Surg	Peds
January 7	OB	Surg	Peds
January 9	OB	Surg	Peds

No. 10

NURSING 204

CLINICAL EXPERIENCE - CLASS SECTION BA - 30 STUDENTS

DATES	GROUP 1 10 Students	GROUP 2 10 Students	GROUP 3 10 Students
Fri., Jan. 31	Peds	OB	Surg
Wed., Feb. 5	Peds	OB	Surg
Fri., Feb. 7	Peds	OB	Surg
Wed., Feb. 12	Peds	OB	Surg
Fri., Feb. 14	Psych F.T.	OB	Surg
Wed., Feb. 19	Psych	Surg	Peds
Fri., Feb. 21	Psych	Surg	Peds
Wed., Feb. 26	Psych	Surg	Peds
Fri., Feb. 28	Psych	Surg	Peds
Wed., March 5	Psych	Surg	Med
Fri., March 7	Psych	ICU	Med
Wed., March 12	Med	ICU	OB
Fri., March 14	Med	Psych F.T.	OB
Wed., March 19	Surg	Psych	OB
Fri., March 21	Surg	Psych	OB
Wed., March 26	Surg	Psych	OB
Fri., March 28	OB	Psych	Med
Wed., Apr. 2	OB	Psych	Med
Wed., Apr. 16	OB	Psych	ICU
Fri., Apr. 18	OB	Med	ICU
Wed., Apr. 23	OB	Med	Psych
Fri., Apr. 25	Med	Med	Psych F.T.
Wed., Apr. 30	Med	Med	Psych
Fri., May 2	Surg	Peds	Psych
Wed., May 7	Surg	Peds	Psych
Fri., May 9	ICU	Peds	Psych
Wed., May 14	ICU	Peds	Psych
Fri., May 16	Emergency	Emergency	Emergency
	Planning	Planning	Planning

No. 11a

No. 11b

SEMESTER	FOCUS	CLINICAL FACILITY	CLINICAL FACILITY
FIRST Fundamentals of Nursing I	Broad generalizations relative to health and presence of Stress "Normal" Problems 1-5 of "Nursing Problems"	Community agencies Medical and Surgical Out Patient Departments	Community agencies Medical-Surgical Obstetrics-Pediatrics Related hospital facilities- OPD
SECOND Fundamentals of Nursing II	Specifics related to disturbed physiological body processes, oxygen, fluid and electrolytes, nutrition, elimination, regulatory. Include Long Term Illness and Emotions.	Medical and Surgical Out Patient Department - Recovery - ICU Rehabilitation	Medical-Surgical Obstetrics-Pediatrics Related hospital facilities- OPD - Rehabilitation Including Psychiatry, Recovery, ICU
THIRD Comprehensive Nursing Care I	Unified concept of Health and Disease Specifics related to Stress and Adaptation Interrelatedness of "Nursing Problems" Emphasis on: 1) Regulatory, Sensory & Motor 2) Oxygen	Medical-Surgical Obstetrics-Pediatrics Psychiatry Related community agencies Related hospital facilities - OPD - Rehabilitation	Medical-Surgical Obstetrics-Pediatrics Psychiatry Related community agencies Related hospital facilities- OPD - Rehabilitation - Recovery - ICU
FOURTH "Synthesis" Comprehensive Nursing Care II	Nursing use of Group Theory Interrelation of "Nursing Problems" Emphasis on Fluid, Electrolytes, Nutrition & Elimination problems Changing patterns of health care (Broad Generalizations)	Medical-Surgical Obstetrics-Pediatrics Psychiatry Related community agencies Related hospital facilities- ICU - ER - Burns- OPD - Rehabilitation	Community facilities Medical-Surgical Obstetrics-Pediatrics Psychiatry Intensive Care Unit Emergency Unit Home Care - Public Health or VNS

A HEALTH CONTINUUM APPROACH TO THE TEACHING OF TECHNICAL NURSING IN AN ASSOCIATE DEGREE PROGRAM

Martha Valliant

The faculty of a new associate degree nursing program, just starting out, have two options in planning the curriculum. They may choose to utilize traditional curriculum concepts, thus producing a diploma or baccalaureate program condensed into two years. Or they may choose to start with a blank piece of paper, creating a curriculum based on these priorities: what is essential; what is not essential but helpful; what is just nice to know. This curriculum is likely to be original and somewhat daring. The faculty must be creative and somewhat courageous.

Fortunately, our chairman believes in the second route. She insisted that the faculty understand what technical nursing is or should be, that the objectives reflect what the technical nurse needs to know in order to practice, that the learning experiences (both theory and practice) that will enable her to practice at the end of four semesters be identified.

During the first two years of the program, the curriculum was divided into three courses: Fundamentals of Nursing, Maternal and Child Nursing, and Physical and Mental Illness. The focus was on the major health problems. At the time, it seemed innovative for us. We were not using systems or diseases, and we certainly were not teaching "everything we knew." We were committed even then to the concept of integration of the traditional content areas, and it was here that we realized that we were not doing as well as we thought. We decided that as long as we had a whole course called Maternal and Child Nursing, we were not integrating. We believed we could.

Thus, at the end of the second year, we retrenched and held a faculty academic conference. We were fortunate to use the facilities of a retreat house high on a mountain, far removed from telephones, children, families, students, and other worldly distractions. For three days we proceeded to tear the curriculum apart. At the end of the conference, we began to see the direction in which we would go. Throughout the summer, we met and struggled and labored and finally produced a curriculum that at least eliminated Fundamentals as such and Maternal and Child Nursing as such. The program was divided into two years of nursing, the first called Physical and Mental Health and the second called Physical and Mental Illness, and it focused around six major problems.

A follow-up conference was held in the fall with a curriculum consultant on hand to listen to and reflect on our deliberations. She informed us that (1) there was not a clear differentiation between the objectives and the content of the two years and (2) the theoretical framework was still obscure. She was right on both counts. Back to the drawing boards.

What was evolving, and still is evolving, is a curriculum based on a concept of the continuum of health, using six arbitrary areas as focal points: stress, oxygen, nutrition, elimination, chemical and neural regulation, and trauma. Woven throughout the four semesters are such threads as growth and development, psychosocial development, communications, observations, and community health.

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Thus, the first-year curriculum is concentrated on the concept of health as a relative state on the continuum of health to illness. Many, but not all, basic skills are learned as a means of maintaining normal physical and mental functions in patients of all age groups. In order to meet a specific objective, such as the learning of techniques in determining vital signs, a student may be assigned to learn these skills on a newborn, a small child, a teen-ager, a postpartum mother, a middle-aged man, or an elderly woman. Or the student may be assigned to visit different areas throughout the community to learn, for example, how the principles of asepsis are carried out.

The second-year curriculum is focused on the relative state of illness on the continuum. Skills learned are those aimed at the restoration toward wellness of those impaired functions related to the physical and mental aspects of the six units. To learn methods of improving the oxygen intake of patients with the loss of aerating lung surface, the student may care for a premature with a hyaline membrane, a child with croup, a teen-ager with pneumonia, an adult with emphysema, or an elderly person with pulmonary edema.

The faculty responsible for teaching in either year must determine the sequence of units, the internal sequence of content of each unit, the objectives to be met, the learning experiences that best meet those objectives, the principles that govern nursing practice, and the best means of evaluating the process of nursing as well as the content.

To demonstrate how the two years utilize the health-illness concept of the various units, it would probably help to select a unit and explain how it is implemented. For purposes of brevity and simplicity, I have selected the unit on nutrition.

In the first year, the unit is titled "The Role of the Nurse in Meeting Normal Nutritional Needs of Individuals of All Age Groups" and focuses on just that. The content includes the socioeconomic and cultural factors of food selection and preparation and the effects of attitude and education on nutritional health. The only hospital diets studied at this time are those that are textural or consistency variations from the regular diet, such as clear and full liquid, soft, and mechanical soft.

To meet specific objectives of this unit, the students may be assigned to study in-depth dietary requirements of various age groups and share their findings with the class. They may interview selected patients who have dietary adaptations of consistency to find out what problems there are in accepting these diets. They may care for patients on selected diets to learn ways of improving appetite and intake in the hospital setting.

In the second year, the course is entitled "The Patient With Problems Related to the Intake and Utilization of Nutrients." The students at this point study the various physical and emotional causes of faulty nutrition, whether they be from the limited intake of food or from impaired absorption or utilization of nutrients. They may, to meet a specific objective, be assigned to care for an infant with a cleft palate, a youth with a fractured jaw, a teen-ager with anorexia nervosa, a poverty-stricken mother, an adult with severe depression, or an elderly person with a malignancy of the stomach. They may be assigned to study ways of improving the nutritional intake of selected persons or families who have dietary restrictions and who come from a variety of socioeconomic and cultural groups.

The principles of maintaining mental health and the nursing interventions involved in caring for a patient with mental illness are developed throughout the curriculum. Students in either course may learn skills at the side of a patient who is either physically or mentally ill or both. The second-year student may practice psychiatric nursing skills on a mental health unit or in the general hospital setting. It is our belief that as a human being is not separated into two compartments, mental and physical, neither

should the nursing curriculum be. The graduate will not be a specialist in either area but will be able to recognize and begin to solve many of the problems that arise in the care of most of her patients. At this time, the curriculum has not revealed any serious weakness. It provides sufficient learning experiences to meet our objectives. It is flexible and can be adapted to future changes in nursing and in the health needs of the community. It allows the selection of a wide variety of learning experiences to meet the objectives. It is as nearly integrated as any curriculum we have seen. Our ongoing evaluation of the curriculum has revealed some dissatisfaction with the stress unit as a unit. It is the present thinking of the faculty that it would be better as a thread that is clearly woven through all the other units. There also seems to be insufficient emphasis on the community health thread, but this will take further evaluation.

In spite of our enthusiasm for this approach, there are a few problems, but none that we feel at this time cannot be worked out. With a continuum approach, there are no clearly defined divisions between the units or between the two years. Thus, there is the danger of repetition or omission. Because the units are so broad, it is sometimes difficult to decide where to place a particular content area or learning experience. We have found that the careful articulation of the units and of the two years that is needed takes an unbelievable amount of faculty time in joint planning, implementation, and evaluation. This is essential if errors are to be avoided. We could take more time if it were available.

As I stated earlier, the faculty is extremely enthusiastic and optimistic about this health continuum approach to the teaching of technical nursing. We would like to believe that it is the way to teach technical nursing, but we do feel confident that it is an effective way to organize the associate degree nursing curriculum.

WHO SHALL TEACH?

Marion I. Murphy

I had mixed reactions after accepting the invitation to be on this very important program and to tackle the controversial topic "Who Shall Teach?" It is true that I have held positions in higher education in three very large state universities for more than two decades, but during that time my efforts have been devoted to baccalaureate and masters education, with emphasis on the latter. Moreover, the only field of nursing in which I have ever practiced, public health nursing, is one that is not represented in the associate degree program nursing curriculum.

On the other hand, I had the good fortune to complete doctoral preparation at the University of Michigan in the program now identified as the Center for the Study of Higher Education, and at least two experiences gained there encouraged me to speak with you today. Dr. Algo D. Henderson, who founded the Center, took a determined stand on the issue that college teachers needed preparation for teaching. Even though his activities along these lines caused raised eyebrows among some of the professional hierarchy of the time, he persevered in organizing demonstrations of good teaching, encouraged student criticism, and lifted the process of teaching to a new level of excellence.

The second influence of the Michigan experience was that the doctoral program in higher education required considerable study of the junior, or community, college movement and associate degree curricula in a variety of fields. This was unique for the early fifties and provided me with a framework to which I could relate nursing in the years that followed.

I would like to begin my discussion by reviewing some rather widely divergent points of view relating to the question, Who shall teach? Eventually, however, I will indicate my own stand even though it may not be a complete answer to the basic issue.

As you are aware, several points of view have previously been expressed on teaching in associate degree programs; among these, probably the most familiar are White's monograph, published by NLN,[1] and the "debate articles" by Schlotfeldt[2] and Montag[3] in the January 1967 issue of Nursing Outlook. More recently, Maureen Maxwell of Loma Linda University tackled the question of preparation for teaching in the Fall 1968 issue of Nursing Forum.[4]

These publications and some others imply that nurse faculty in an associate degree program should have masters or higher preparation--it was the balance of what the educational program contained that was at issue. But some of the controversy going on today within nursing and elsewhere in allied health programs regarding the question of who shall teach raises questions of a more elementary and to me a more threatening nature. Let me give some examples.

At a meeting of deans and directors of four-year collegiate schools, the question of masters study was under discussion and mention was made of the extreme need for teachers in associate degree nursing programs. One point of view expressed was that

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this was a problem for community colleges--not for four-year schools of professional nursing or for masters programs. Further defense of this stand pointed out that four-year professional graduates still constituted only a minority and that main effort should be expended toward enabling them to nurse patients. I cite this somewhat extreme example to illustrate the rather understandable concern of generic professional nursing education that its graduates fulfill the role of professional general practitioner for which they have been prepared rather than be drafted, before or after masters study, to prepare nurse technicians. Further discussion at the same meeting raised a question as to whether recent developments in both baccalaureate and masters curricula--pertaining to what and how students were taught nursing--would make the task of converting the graduate into a teacher for an A.D. program even more difficult than in the case of a diploma graduate with a more traditional functional preparation for teaching. I will come back to both of these comments later, but I am presenting them now to illustrate a point of view that seems to dissociate or even deny connection between the two types of education for nursing practice, professional and technical, as far as preparation of teachers is concerned. This might be termed the "Let them take care of themselves" point of view!

I would like to shift now to the broader area of what is coming to be known as the field of allied health encompassing both baccalaureate and associate degree programs. During recent months,I have been serving as chairman of a committee on the Allied Health Professions on our Baltimore campus and in the process have reviewed bulletins from various parts of the country and listened to reviews of curricula in a number of allied fields. Our committee is concerned only with four-year programs but in review and discussion often acknowledges two-year programs in the same or related health areas. I would like to focus for a moment's comparison on who teaches in such programs. In the case of some of the allied programs that were previously or are presently maintained by hospitals and that now aspire to baccalaureate degree status, one is struck by a historical comparison with nursing. All of the same problems are there--i.e., large amounts of clinical practice with a very loose relationship to earned college credit, a tendency to define the major as teaching or administration rather than clinical content, and acceptance of baccalaureate prepared teachers. In comparison, my rather superficial review would indicate that associate degree programs preparing, for instance, a radiologic technician or an occupational therapy assistant have stated more clearly the relationship between general and technical components of the curriculum and take responsibility for field or clinical practice as an integral part of the whole. There is one similarity, unfortunately, and that is some acceptance of baccalaureate graduates as faculty.

With regard to the latter, the School of Health Related Professions at the State University of New York at Buffalo publicizes a ten-month Teacher Preparation Program entitled "Community College Teaching in Health Related Programs.[5] The announcement of career opportunities in community colleges says that teacher preparation is available in the fields of Biomedical Engineering Technology, Dental Assisting, Environmental Health Technology, Medical Record Technology, and Occupational Therapy Assisting. It was the criteria for selection of prospective teachers that jolted me a bit, for they include the following: preference is given to a baccalaureate degree, but applicants with an associate degree or no degree will be considered; experience of at least three years in the specific area is required, as are references. The School of Health Related Professions is supported in part by a grant from the W. K. Kellogg Foundation.

In summary, a common theme that can be identified in literature describing the new allied health fields goes something like this: "With increasing technological manpower demands, the need for prepared community college teachers in health technologies far surpasses the supply."[6] While my purpose in citing information from allied health fields was to draw comparisons with nursing, I should now like to state firmly that here my parallel ends. In the case of associate degree programs in nursing, we are preparing a technical nurse who is to become a licensed practitioner. Moreover, in the position paper on education for nursing published by our professional Association,[7] the responsibilities of this practitioner are described as providing nursing care that is unlimited in depth, but limited in scope. "It must be rendered, under the direction of professional nurse practitioners, by persons who are selected with care and educated within the system of higher education; . . ."[8] As an occupational field grows more complicated, as is the case with nursing, both societal and technological trends have dictated that in terms of manpower, very large groups need technical education such as can be obtained in an associate degree program, while smaller groups need more intensive, more expensive professional education. Hence, the position that I shall take in the remainder of this discussion is that associate degree programs in nursing must have faculty with masters (or higher) preparation just as rapidly as the profession can prepare them. I would state further that the future of safe nursing care for people in this country is dependent upon the speed with which this can be accomplished. For this reason I cannot agree with the philosophy expressed by some of my colleagues that who teaches in A.D. programs is none of our concern in baccalaureate or graduate education. I say that we have moral as well as professional responsibility to contribute leadership to the preparation of those who, according to all manpower predictions, are destined to give a great deal of the caring and comforting and curing and coordinating that we call nursing. I realize that you are having to use some baccalaureate graduates to assist but hope you will keep the difference in preparation clear and always assign them to work with prepared teachers.

I have thus aligned myself with the need of A.D. programs for good teachers who have had advanced (masters level) education in nursing plus some preparation for teaching--but this is only a beginning. It is the ways and means of accomplishing this goal that are troubling the minds of many thoughtful educators in nursing today. Probably quite a few would agree with Dr. Montag's comment in the Outlook article that the ANA Position Paper of 1965 seemed to imply that nursing was subscribing to the point of view that to be knowledgeable about a subject is to be able to teach it. One should not forget, however, that since the Position Paper dealt primarily with the education of nurse practitioners, statements concerning more advanced preparation--i.e., at the masters level--were necessarily abbreviated and hence subject to misinterpretation. I believe that it is important for an audience like this to know that a second ANA paper, dealing with graduate education in nursing, has been in the process of preparation for over a year and hopefully will reach publication this spring. While emphasizing that the core of advanced preparation in nursing is nursing, recognition also is given to the reality of the existence of a body of knowledge concerning the science and art of education and that certain students will elect to secure preparation in this area. Thus, it is hoped that the statement on graduate education will clear away a lot of confusion and provide a rallying point around which graduate programs in nursing can and will develop realistic preparation for leadership in the world of nursing today.

Optimistic as I am concerning this matter, we still are not "off the hook" as far as the preparation of teachers for A.D. nursing programs is concerned. The thorny issue about which there has been controversy and that so far has escaped resolution is the extent of difference in preparation for those who are to teach in baccalaureate programs and those who are to teach in associate degree programs. I would like to approach this question from two fronts--clinical preparation and preparation for teaching. First, however, I should add that in my opinion, any graduate program that purports to prepare a nurse for a leadership position, whether practitioner, teacher, administrator, or investigator, should contain content that furthers understanding of developments and trends in nursing education in the United States. In my experience, graduate students, young or not so young, are unbelievably ignorant concerning the junior college movement or its implications for nursing. They all need to improve their knowledge and understanding on this score, or they will be ill-prepared to assume any leadership role in nursing. Perhaps we need to be reminded, in John Gardner's words, that "The greatest American educational invention of the nineteenth century was the land-grant college. The greatest American educational invention of the twentieth century is the two-year community college."[9]

I believe that we all would agree that the program followed by the prospective A.D. teacher should contain sufficient theoretical and clinical nursing experiences to allow her to earn the master-practitioner label. One problem, however, lies in the diversity in appropriate clinical nursing situations. The growth of knowledge and what some call "branching," whereby new discoveries give rise to distinct new subspecializations and fields, is a phenomenon with which universities are coping at both undergraduate and graduate levels.[10] Thus, with the tremendous increase in knowledge in the generic health field as well as the growing tendency on the part of advanced nursing students to throw off the traditional shackles of the medical-surgical, psychiatric, or other area of nursing, graduate students of the future may legitimately pursue a narrower field of clinical specialization than is the usual case today. Personally, I am not so sure that this will prove to be a handicap, for a soundly designed masters program should have a sufficiently broad base of knowledge from related biological and/or social-behavioral sciences to provide a take-off in a number of clinical directions. Also, when we become too fearful lest our masters graduate may not fit into what is expected of her as a teacher in an A.D. program, I believe we forget that the need for continued learning must be part of the warp and woof of advanced education. In his provocative book on general education, David Bell emphasizes, "But the newest and greatest need is for continuing post-graduate education."[11] Maxwell's article points out that the date of a teacher's preparation is an important factor, since changes in concepts about nursing and about education have been rapid.

Probably no matter how closely we tried to tailor a masters program in nursing to the exact requirements of a specific type of position, there always would (or should be) unexpected variations and adaptations required of the graduate. It is my feeling that masters programs in nursing could cope with these challenges along more innovative lines than are usually visible today. For instance, last summer at the University of Maryland we initiated a variation in our masters program in psychiatric nursing.[12] Two courses on theory and clinical experience in psychiatric nursing were offered, and two more advanced courses will be made available to the same students during the 1969 summer session. This "package" is meeting the needs of a number of A.D. faculty who already have masters preparation in another clinical area. Those who are earning a

first masters degree will have to enroll for an academic year in order to complete the program, including a final semester that combines preparation for teaching with other learning. We were able to secure N.I.M.H. traineeships for both types of students--we enrolled over our expected number last summer and have about four times as many applications as we can handle from new students for this summer.

In our situation we feel that this is only a beginning, for why shouldn't a graduate program in nursing try to help meet this type of need and to fill in the gaps that exist in some of the other clinical areas as far as A.D. teaching is concerned? In so doing, we need not weaken or distort our original program concept, provided, of course, that the graduate program had a philosophy and a purposeful plan of operation in the beginning. Graduate education and graduate schools in the United States have been slow in changing from the German university research-oriented pattern initiated during the latter half of the last century. But changes are taking place, and reasonable proposals from a professional school are apt to secure approval of a graduate school council. When I hear about graduate programs in nursing that reject innovative ideas on the grounds that the graduate school would not approve, I wonder who may be kidding whom.

Let us turn now to the problems of appropriate preparation of the master nurse-practitioner to teach in an associate degree program. By "appropriate" I mean something beyond broad courses involving philosophy of education, the teaching-learning process, or general principles of curriculum planning and evaluation that might well be shared with students preparing for baccalaureate teaching. There needs to be a dividing point. Here I believe the graduate program in nursing has responsibility to gear what we have tended to call "functional" preparation to the community college setting. I am coming to resist the term "functional" (as opposed to "clinical") because I believe so strongly that what we teach must be fundamentally intertwined with "how." Regardless of what we may call it, here is where the prospective teacher should have guided opportunity to become more deeply involved with the philosophic foundations, the differences in approach and ways of reaching educational goals that characterize associate degree education in nursing. Also, whatever philosophy guides the graduate program's requirement for a practicum, the prospective A.D. teacher should have this experience in an associate degree setting. I have purposely implied that a modern practicum ought to be broader than much of our traditional practice teaching experience--it should include various theoretical and practical opportunities for the neophyte teacher to begin to identify with the role--and some of these activities will be far afield from the preparation of a teaching unit and the teaching of part of it! Graduate programs fortunate enough to have nursing faculty with depth of understanding of both baccalaureate and associate degree education should be able to communicate understanding of differential aspects to students. Maxwell raises the question:

> What do the graduates from baccalaureate degree programs need to know about crisis or pain or tracheostomy care that is different from the knowledge needed by the graduates from diploma or associate degree programs? How does teaching about crisis in a community college differ from the way it might be taught in a university? This problem of differentiating content and teaching methods might be put before graduate students, who, in dealing with it, would acquire skill in analyzing knowledge and selecting teaching approaches appropriate to different educational

> levels. At the same time this type of exercise might help the next generation of nurses to be clearer about roles and objectives than our generation is today.[13]

So far so good--but now let me turn our attention to difficulties that many graduate programs in nursing are encountering (or will encounter) in trying to provide such preparation. Traditionally, we (speaking generically) have utilized baccalaureate and diploma programs for what we tend to refer to as practice teaching--and many graduate programs, instead of being in the vanguard of what was happening in nursing education, have continued along the same lines, seeming to ignore the associate degree setting. Probably one of the biggest reasons is that many graduate programs lack faculty who themselves are knowledgeable concerning A.D. education in nursing. There are other practical considerations. Because our faculties may have very superficial understanding of the organization of an A.D. curriculum in nursing, they may hesitate to try to fit their prospective teachers with clinical majors such as psychiatric or maternity nursing into your program. Timing, also, is a factor, for the semester when you could accommodate practice students, we don't have them ready, et cetera. In some instances, distance to an appropriate A.D. program may be a factor, but this problem will be diminishing with the increase in these programs in most states. I am reciting these very real problems, not because I think any one of them is insurmountable, but simply to emphasize that you are a different ball park and it is going to take time for us to feel comfortable there. In fact, I wonder if our greater ease of movement between baccalaureate and diploma education isn't an indictment of our dependency upon old ways and hesitancy to espouse the new. Pearl Coulter, at the time of her retirement as dean of a four-year school of nursing, suggested that the associate degree programs at their best had shown more creativity in their approach to teaching nursing than had either baccalaureate or diploma programs.[14]

I suppose two alternatives that face us in graduate education are (1) the rapid development of a number of innovative approaches designed to bridge the gap and (2) the development of separate majors for those preparing to teach nursing in A.D. programs. Under the former heading I would group the short summer courses that have been offered by Teachers' College, Columbia University, and the University of Tennessee and the one that will be offered at the University of Maryland this summer. I realize that other schools have been involved in similar activity. One possible source of recruits is post-masters nurses who completed graduate education as clinical specialists with no formal preparation for teaching. It reportedly is difficult for this group to fit into either baccalaureate or associate degree positions with only on-the-job orientation--their needs seem to deserve separate consideration. I believe that many graduate programs in nursing could find a way to offer a background course dealing with the community college taught by a general educator, preferably in evening and summer sessions. I also believe, but cannot speak for my colleagues in other graduate programs, that as we gain experience--for instance, in our summer psychiatric nursing program at Maryland--we may become more knowledgeable concerning the "overlay" of advanced clinical content from one area or another and be able to apply this concept in design of a masters curriculum. I have been using the term "overlay," but when I looked it up in the dictionary, I wasn't satisfied that I was correct. It helped me to clarify what I meant when I noted that Bell described the addition of required humanities courses to otherwise "technological training" as "overlay." He carefully differentiated, however, that the overlay, necessary

as it was to the rounding out of education, did not constitute (a second) specialty preparation.[15]

I am not prepared to deal with my second alternative, the setting up of more graduate curricula with a specific design and goal of preparing teachers for A.D. programs in nursing. There are a number of nursing educators who are prepared to elaborate on the advantages of such planning and who defend it as a more direct line to accomplishing the desired result in terms of number and quality of teachers.

In summary, I believe that well-prepared nurses, described by Schlotfeldt as "competent professionals," should teach in programs that prepare nursing technicians. In order to prepare them in numbers, I believe that each graduate program in nursing must examine its conscience and continue to give thought to its rationale for offering advanced preparation. This will involve not only shoring up foundational and clinical bases but also permitting students to elect theoretical and functional preparation in a field of practice such as teaching. I believe that all graduate education in nursing should include understanding of trends in higher education in the United States and the relationship of these to nursing as well as to the general field of the health professions and occupations.

In trying to cope with your question, Who shall teach? I realize that I may have seemed to bounce back and forth between providing a "cookbook" and at the same time suggesting that deeper theoretical considerations are involved.

Finally, I believe that the answer to the question of who shall teach in associate degree programs will be found as graduate programs in nursing continue to seek and find innovative approaches and are willing to build bridges between the here and now and the future.

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